Legislative Report

# Plan for Implementation of Independent Assessments on Mental Health Services

Session Law 2010-31
Section 10.36

## State of North Carolina

## Department of Health and Human Services

## Division of Medical Assistance and Division of Mental Health, Developmental Disabilities and Substance Abuse Services

**May 31, 2011**

## Legislative Mandate

Session Law 2010-31, Section 10.36 mandates that the Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) require an initial assessment or continuing need reassessment be completed for Medicaid recipients by an independent assessment entity prior to the delivery of an enhanced mental health service [subsection (a)]. The assessment or continuing need reassessment would recommend the type and amount of service to be delivered based upon the needs and condition of the recipient. The goal of implementing this requirement would be to achieve cost savings within the Medicaid program.

Further, subsection (b) of the law requires that if the cost savings are not realized in implementing the independent assessment requirement, DHHS shall additionally require targeted independent assessments be completed by an independent assessment entity prior to service delivery for all Medicaid recipients in each of the following categories: those exiting inpatient facilities, those determined to be high cost/high risk individuals with high behavioral health or medical needs, those for whom continuing care authorizations are requested, and those moving to more intensive levels of care.

A report on the cost savings and other findings shall be submitted to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division [subsection (c)]. This report is submitted to fulfill this requirement.

## Current Assessment Requirements

The mental health, developmental disability, and substance abuse service delivery system is currently designed such that an assessment is required prior to delivery of any enhanced behavioral health service. DMA Clinical Coverage Policy 8A requires a determination of medical necessity prior to the delivery of any of the enhanced benefit services. Medical necessity is discerned through a comprehensive assessment of an individual's needs. For example, the mental health service definitions for Child and Adolescent Day Treatment, Community Support Team, Intensive In-Home, and Multisystemic Therapy Services contain the following statement among the entrance criteria: "*A comprehensive clinical assessment that demonstrates medical necessity shall be completed prior to provision of this service".*

Implementation Update #36, *Changes to Implementation Updates, Community Support Service, Comprehensive Clinical Assessment, Training, and CAP-MR/DD Endorsement,* jointly issued by the DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) November 5, 2007, sets forth the definition and requirements for the comprehensive clinical assessment that must be completed prior to the

delivery of an enhanced behavioral health service. The comprehensive clinical assessment is defined as "*an intensive clinical and functional face-to-face evaluation of an individual's…condition…"* The assessment must be completed by qualified individuals who are licensed or provisionally licensed and may be billed through a variety of procedure codes.

The comprehensive clinical assessment must include, at a minimum, the following elements:

- a chronological general health and behavioral health history of the individual's symptoms, treatment, and outcomes;
- biological, psychological, familial, social, developmental and environmental dimensions that identify strengths, weaknesses, risks, and protective factors in each area;
- a description of the presenting problem including precipitating events and current medications;
- a strengths/protective factors and problem summary which addresses risk of harm and functional status;
- a strengths based assessment of family and natural supports to include preferences, needs, and cultural diversity issues;
- evidence of recipient's or, where applicable, legally responsible person's involvement in the assessment;
- an analysis of information with a case formulation;
- diagnoses on all five axes of the DSM-IV; and
- recommendations for additional assessments, services, support or treatment based upon the results of the comprehensive assessment.

Furthermore, assessment has been identified as one of the three core services provided by a Critical Access Behavioral Health Agency (CABHA), a comprehensive provider offering an array of services. To maintain clinical integrity, the CABHA must uphold its role in assessing individuals at the beginning of and throughout their treatment.

As previously stated, the system is currently designed such that assessments are being completed prior to service delivery. For example, Medicaid paid claims data for the State Fiscal Year (SFY) 2010 show that 40,915 assessments were provided to individuals either newly entering the system or inactive (i.e., no services received for a period of at least 60 days) at a cost of $4,817,859.52. However, DHHS perceives the actual problem is that assessment results are not always being utilized in the service planning process. For example, the DMH/DD/SAS Accountability Team completed audits for 41 Intensive In-Home (IIH) providers and 44 Community Support Team (CST) providers during the fall of 2009. The audit findings were that 61% (i.e., 372 of 615) of IIH events reviewed and 41% (i.e., 270 of 660) of CST events reviewed documented services provided to individuals who did not meet the medical necessity requirements for the respective services. In other words, the results of the assessment in the record reviewed did not indicate that the recipient met the eligibility criteria for IIH, for example,

but the person centered plan or the request for service authorization was written in such a way that the service was authorized and delivered. These findings indicate a system issue – that some service providers do not accurately incorporate the assessment results into the formulation of the person centered plan, resulting in an inappropriate service (i.e., a service not medically necessary or clinically indicated) being provided.

**Challenges to Implementation of the Legislative Requirements**

As indicated, Medicaid paid claims data for the SFY 2010 show that 40,915 assessments were provided to individuals either newly entering the system or inactive (i.e., no services received for a period of at least 60 days) at a cost of $4,817,859.52. Implementing the legislation as written would have resulted in additional costs to the mh/dd/sa service delivery system and would have required policy changes. For example, the cost for an assessment can range from $96.22, the Clinical Intake procedure code, to $236.02 for a Diagnostic Assessment – an enhanced benefit service completed by a minimum of two evaluators, per assessment depending upon the procedure code utilized. If a comprehensive clinical assessment from an independent assessment agency were to have been mandated during SFY 2010 for each of 40,000 recipients, the resulting additional cost would have ranged from $3,848,800 utilizing the Clinical Intake procedure code for each person to $9,440,800 utilizing the Diagnostic Assessment code for each. Even if an average of $166.12 is used for each of the 40,000 recipients, the additional costs would have approximated $6,644,800. Those additional costs had not been anticipated or incorporated into the service delivery system for the SFY.

In an effort to address the legislative mandate the DHHS began working in July of 2010 to create an independent assessment process that could perhaps achieve savings within the current system.

**The Planning Process and Proposed Plan**

The DHHS has undertaken the task of creating a plan to implement the process of identifying consumers in need of an independent assessment, pursuant to the legislation, arranging for the assessment through the Local Management Entity (LME) and analyzing the financial impact of these assessments and the subsequent service provision on the mental health service delivery system.

The goals reflected in the independent assessment guidelines include:

- implementing the provision in a manner that does not create barriers or delays to accessing medically necessary services;
- utilizing existing resources rather than creating new infrastructure(s);
- integrating the independent assessments into the current authorization process; and
- ensuring that the assessment role of the Critical Access Behavioral Health Agency (CABHA) is not undermined (i.e., that the independent assessment

process developed supplements rather than supplants the CABHA's assessment role)

The DMA collaborated with DMH/DD/SAS to create a plan incorporating guidelines for two complementary processes: quality of care oversight and independent assessments. The plan was presented to stakeholders for discussion and feedback. The stakeholders included representatives from the North Carolina Psychological Association, the North Carolina Psychiatric Association, the utilization review vendors, the DMH/DD/SAS External Advisory Team, and members of the North Carolina Council of Community Programs. All stakeholders have responded favorably to the proposed plan, and the plan was reviewed and approved by the DMA Physicians' Advisory Group (PAG) as well as the DMA / DMH/DD/SAS Leadership Policy Group.

The independent assessment guidelines have been assigned to the DMA / DMH/DD/SAS Quality of Care (QOC) Committee for implementation (no later than October 1, 2011) and oversight. The members of this committee include licensed clinicians and quality management staff from DMA's Clinical Policy, Program Integrity and Information Technology Sections and from DMH/DD/SAS's Accountability Team, licensed clinicians from the Consumer Advocacy and LME Teams, and staff from the Quality Management Team. Two DMH/DD/SAS representatives who serve on the DMA / DMH/DD/SAS Quality of Care Committee also serve on the DMH/DD/SAS Quality Improvement Committee, chaired by the DMH/DD/SAS Medical Director. This provides a second level of clinical oversight.

The independent assessment guidelines utilize the working relationships among the DHHS, the LMEs and the utilization review (UR) vendors. The guidelines address provider assessments on the provider (i.e., system) level and on the level of the individual recipient. The system/provider level intervention occurs through the identification of providers who have high denial rates for requests for authorization of services. The UR vendors provide monthly data to DMA regarding the prior authorization requests for enhanced services. The data include the number of requests authorized, requests denied and requests that required additional information. These numbers will be reviewed by the QOC Committee. Providers who are the outliers per the benchmarks identified by the QOC Committee shall be referred to the endorsing LME for a chart review.

The QOC Committee shall designate a random sample of records for review by the LME no later than January 1, 2012. The LME's review of these records will include an analysis of the clinical assessment in conjunction with the recipient's treatment plan (i.e., Person Centered Plan) to determine that the services ordered are indicated in the assessment and that both processes are congruent with best practice guidelines. Necessary corrective action will be identified by the LME and required of the provider. There may also be potential referrals to other agencies for follow up (e.g., DMA Program Integrity or DMH/DD/SAS).

The second level of intervention will review recipient service requests submitted to the UR vendors that are flagged as cases of concern or as needing a level of care review. Individual recipients whose request for services presents complex symptomology and/or complex service needs such that services the provider has requested appear inadequate to address the problem will be identified by the UR vendor, and referred to the LME for review and LME involvement in planning for assessment/services. Level of care referrals are made due to an individual recipient's request for services exceeding benchmarks identified by the DHHS for that particular service. The benchmarks for the services below are as indicated:

- Assertive Community Treatment Team (ACTT) – 18 months;
- Psychosocial Rehabilitation (PSR) – 18 months;
- Intensive In Home (IIH) – 6 months;
- Day Treatment - 6 months;
- Mental Health/Substance Abuse Targeted Case Management –7 months;
- Out of home placement – 12 months; and
- Out of state placement – 12 months.

For the identified individual recipients, the LME's Care Coordination Department shall perform a clinical chart review and coordinate recommended assessments and or services. Any necessary corrective action will be identified by the LME and required of the provider. There may also be potential referral to other agencies for follow up (e.g., DMA Program Integrity or DMH/DD/SAS).

**Conclusions**

Properly implemented, it is anticipated that the proposed independent assessment guidelines will result in cost savings for the Medicaid Program. Existing resources including the CABHA infrastructure, and existing Clinical Coverage Policy 8A as well as the current comprehensive clinical assessment process will be used resulting in minimal upheaval and cost to the existing provider system. Monitoring by the joint DMA / DMH/DD/SAS Quality of Care Committee will allow for oversight by an existing entity, and thus eliminate the need for additional state staff resources. UR vendors and LMEs currently participate in the quality of care process, and thus there will be no additional expenses related to vendor contracts or LME funding. Through the two processes by which independent assessment is addressed, quality of care is expected to improve and, ultimately, Medicaid costs will be reduced as individuals are directed to clinically appropriate services. Finally, it is anticipated that permitting the independent assessment to occur as outlined herein will minimize additional costs to the mh/dd/sa service delivery system, and facilitate realization of the legislative mandate to determine what costs savings could be realized by requiring the completion of an independent assessment by a provider not affiliated with the provision of a recipient's services.